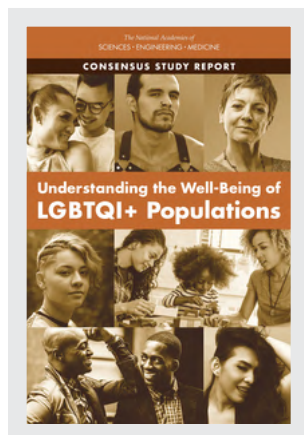


# EXHIBIT G

Declaration of Omar Gonzalez-Pagan in support of  
Motion to Exclude Expert Testimony of Dr. Paul R. McHugh  
*Kadel v. Folwell*, No. 1:19-cv-00272-LCB-LPA (M.D.N.C.)

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### CONTRIBUTORS

Charlotte J. Patterson, Mart n-Jos Sep lveda, and Jordyn White, Editors;  
Committee on Understanding the Well-Being of Sexual and Gender Diverse  
Populations; Committee on Population; Division of Behavioral and Social  
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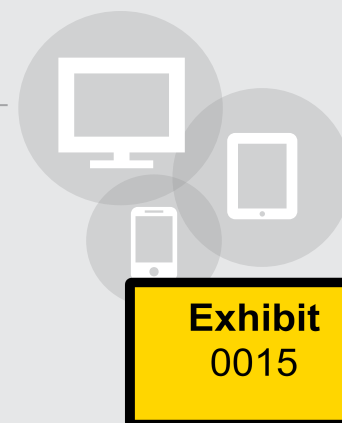
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# Understanding the Well-Being of LGBTQI+ Populations

Committee on Understanding the Well-Being of Sexual and  
Gender Diverse Populations

Charlotte J. Patterson, Martín-José Sepúlveda, and Jordyn White, *Editors*

Committee on Population

Division of Behavioral and Social Sciences and Education

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## Guidelines and Policies Related to Gender Affirmation

Clinicians who provide gender-affirming psychosocial and medical services in the United States are informed by expert evidence-based guidelines. In 2012, the World Professional Association for Transgender Health (WPATH) published version 7 of the *Standards of Care for the Health of Transgender, Transsexual, and Gender-Nonconforming People*, which have been continuously maintained since 1979, and revisions for version 8 are currently underway (Coleman et al., 2012). Two newer guidelines have also been published by the Endocrine Society (Hembree et al., 2017) and the Center of Excellence for Transgender Health (UCSF Transgender Care, 2016). Each set of guidelines is informed by the best available data and is intended to be flexible and holistic in application to individual people. All of the guidelines recommend psychosocial support in tandem with physical interventions and suggest timing interventions to optimize an individual's ability to give informed consent. Mental and physical health problems need not be resolved before a person can begin a process of medical gender affirmation, but they should be managed sufficiently such that they do not interfere with treatment.

A major success of these guidelines has been identifying evidence and establishing expert consensus that gender-affirming care is medically necessary and, further, that withholding this care is not a neutral option (World Professional Association for Transgender Health, 2016). A number of professional medical organizations have joined WPATH in recognizing that gender-affirming care is medically necessary for transgender people because it reduces distress and promotes well-being, while withholding care increases distress and decreases well-being (AMA, 2008; American Psychiatric Association, 2018; American Psychological Association (APA), 2008, 2015; American Academy of Family Physicians, 2012; American Academy of Pediatrics, 2018; American College of Nurse-Midwives, 2012; American College of Obstetricians and Gynecologists, 2011; Endocrine Society, 2017). Accordingly, public and private insurers have expanded access to gender-affirming care; some have done so proactively, while others have been required by state and federal nondiscrimination laws to remove coverage exclusions (Baker, 2017).

Coverage requirements for gender-affirming care typically rely on an overarching principle of parity between medically necessary services for transgender and cisgender people. Treatments that are gender-affirming for transgender patients are covered by public and private insurers for intersex and cisgender people for a variety of conditions, including genital difference, endocrine disorders, cancer prevention or treatment, and reconstructive surgeries following an injury. Examples of these services include testosterone or estrogen replacement therapy after surgery or menopause, vaginoplasty after pelvic surgery or for women with vaginal agenesis in the context of an intersex condition, and phalloplasty for cisgender male service members injured in war (Spade et al., 2009; Baker et al., 2012; Balzano and Hudak, 2018).

As this report goes to press, 24 states and the District of Columbia have enacted laws or made administrative changes prohibiting transgender-specific insurance exclusions in private coverage (Movement Advancement Project, 2020a). However, Medicaid programs in 10 states continue to explicitly exclude gender-affirming care for transgender individuals, and many states do not address the issue of this coverage in Medicaid (Mallory and Tentindo, 2019). At the federal level, the Medicare program removed its exclusion for "transsexual surgery" in 2014 (U.S. Department of Health and Human Services, 2014), though coverage decisions related to gender-affirming surgeries are still made on a case-by-case basis (CMS, 2016). As discussed

European samples, a United States-based comprehensive registry that tracks patient-centered outcomes for both youth and adults could lead to valuable insights on the benefits of medically supervised gender affirmation (Kimberly et al., 2018). Much remains to be learned regarding optimal timing and risk profiles for surgeries and other medical interventions, aided by standardized and validated tools for body satisfaction, gender-related quality of life, gender dysphoria, and mental health (Olson et al., 2016). Standardized assessment and reporting of outcomes are particularly essential for helping clinicians and patients understand surgical options. In this area, too, more attention is needed to populations that tend to be invisible or underrepresented in clinical research, especially transgender people of color and non-binary individuals. Very little is known about the experiences and options for treatment for transgender individuals with intersex traits, especially those who had irreversible treatments as children. Overall, however, the evidence indicates that gender-affirming interventions, including social affirmation, hormonal treatment, and surgeries, are medically necessary for reducing distress and improving the health and well-being of transgender people.

## CONVERSION THERAPY

Efforts to change sexual orientation or gender identity, which initially gained traction in the 1960s and which are often referred to as conversion or reparative therapies, assume that non-cisgender and non-heterosexual identities are abnormal. In 2009 the American Psychological Association (APA) produced a landmark report that systematically reviewed the evidence of efficacy for sexual orientation change efforts (APA, 2009). Most of this research was conducted prior to 1981, and very few studies were experimental in design. The task force found that some people sought sexual orientation change efforts due to distress over their sexual orientation but that the treatments were unable to reduce same-sex attractions or increase other-sex attractions. Furthermore, there was evidence that individuals experienced harm from these treatments, including sexual dysfunction, depression, anxiety, and suicidality. With regard to gender identity, while interest in the so-called “desistence” of transgender identity has been informed by studies suggesting that as high as 80 percent of prepubertal youth presenting to pediatric gender clinics ultimately do not identify as transgender, many of the youth included in these studies did not meet full DSM criteria for a gender incongruence diagnosis (Olson, 2009). Recent evidence supports that early social affirmation of transgender identity is associated with good outcomes (Olson et al., 2016; Durwood, McLaughlin, and Olson, 2017) and that lack of social affirmation correlates with depression, anxiety, and suicidality (de Vries et al., 2016; James et al., 2016).

Consequently, sexual orientation and gender identity conversion efforts have fallen out of favor in mainstream psychological and psychiatric practice. By the time of the 2011 Institute of Medicine report, many medical organizations had issued statements condemning sexual orientation change efforts based on the lack of efficacy and evidence of harm. Many of these organizations have since updated their positions to decry conversion therapy for both sexual orientation and gender identity (Streed et al., 2019a; SAMHSA, 2015; Rafferty et al., 2018; American Academy of Child and Adolescent Psychiatry, 2018; AMA and GLMA, 2018).

However, there is recent evidence that LGBTQ youth and adults continue to be exposed to conversion therapy. A 2019 report from the Williams Institute estimated that 698,000 adults between ages 18 and 59 have undergone conversion therapy from a licensed professional or religious advisor, of whom 350,000 were adolescents when treated (Mallory, Brown, and Conron, 2015). The same study estimated that an additional 57,000 youth will receive conversion



therapy from a health care or religious provider before 18 years of age. Among 25,000 LGBTQ youth respondents to a 2019 national survey, 67 percent reported that someone attempted to convince them to change their gender identity or sexual orientation (Trevor Project, 2019). A survey of 762 marriage and family therapists and members of the American Academy of Marriage and Family Therapists, which has a position statement against conversion therapy, found that 19.4 percent of respondents believed it was ethical to practice sexual orientation change therapy, and 3.5 percent of respondents had done so. This belief was associated with higher levels of negative beliefs about LGB clients than those of other therapists (McGeorge, Carlson, and Toomey, 2015).

A recent survey was among the first to evaluate the link between sexual orientation change therapy and the health of young people: among 245 white and Latinx LGBT individuals between the ages of 21 and 25, exposure to conversion efforts within or outside of their families during adolescence was associated with higher family religiosity, lower family socioeconomic status, and higher individual gender nonconformity (Ryan et al., 2018). In addition, exposure to conversion efforts during adolescence was significantly associated with increased suicidal ideation, suicide attempts, and depression, as well as diminished life satisfaction, self-esteem, social support, educational attainment, and lower income in young adulthood.

A systematic narrative review of gender identity conversion efforts found few data and a notable absence of research about their effects on both adolescents and adults (Wright, Candy, and King, 2018). However, a recent study using data from the 2015 USTS found that 14 percent of respondents had been exposed to gender identity conversion therapy during their lifetimes; exposure was associated with significantly higher rates of past-month severe psychological distress and lifetime suicide attempts compared with respondents who had not been exposed to such therapy (Turban et al., 2019). Exposure to gender identity conversion therapy before age 10 was associated with nearly twice the rate of lifetime suicide attempts.

The available evidence suggests that sexual orientation and gender identity conversion efforts are ineffective and dangerously detrimental to the health of SGD populations, especially for minors who are unable to give informed consent. As of early 2020, 20 states, the District of Columbia, Puerto Rico, and a number of municipalities had outlawed sexual orientation and gender identity conversion therapy for minors (Movement Advancement Project, 2020d). As growing numbers of professional organizations and governments call for or legislate an end to conversion therapy, particularly for minors, it is important for clinicians working with SGD populations to understand the effects that these experiences can have on individuals, even many years later. Research on strategies for helping individuals who have experienced conversion therapy to heal and recover is essential. In order to end the practice of conversion therapy, it is not sufficient for professional organizations to recommend against conversion therapy; rather, professionals may require dedicated and specific training on the inefficacy and danger of conversion treatments, and insurance providers should consider limiting coverage for these non-evidence-based practices.

## INTERSEX GENITAL SURGERY

The most expansive estimations of the prevalence of intersex traits, including any variation in any marker of sex (chromosomes, internal reproductive anatomy, external genital shape, and secondary sex traits) concludes that up to 1.7 percent of the population has an intersex trait (Fausto-Sterling, 2000). Estimates based on the number of people with clinically identifiable